



## General

### Guideline Title

Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American Society of Clinical Oncology guideline adaptation.

### Bibliographic Source(s)

Andersen BL, DeRubeis RJ, Berman BS, Gruman J, Champion VL, Massie MJ, Holland JC, Partridge AH, Bak K, Somerfield MR, Rowland JH, American Society of Clinical Oncology. Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American Society of Clinical Oncology guideline adaptation. *J Clin Oncol*. 2014 May 20;32(15):1605-19. [87 references] [PubMed](#)

### Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Recommendations

### Major Recommendations

The sections that follow present the recommendations adapted from the pan-Canadian guideline on screening, assessment, and treatment and care options for depressive symptoms, followed by recommended screening, assessment, and treatment, and care options for anxiety symptoms. Where identified by an asterisk, recommendations are taken verbatim from the pan-Canadian guideline. Otherwise, recommendations have been adapted by the American Society of Clinical Oncology (ASCO) panel. Recommendations on follow-up and reassessment of symptoms of depression and anxiety were based solely on the consensus of the ASCO panel.

#### Recommendations of Screening, Assessment, and Treatment and Care Options for Depressive Symptoms

Figure 1 in the original guideline document presents a screening, assessment, and care algorithm for depression adapted from the pan-Canadian guideline. The algorithm was modified to reflect the ASCO panel's adapted recommendations. Of particular note, references to the Edmonton Symptom Assessment Scale (ESAS) screening measure in the recommendations and the algorithm were removed as this measure is not widely used in the United States.

#### Screening

- All patients should be screened for depressive symptoms at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease or treatment status (i.e., post-treatment, recurrence, progression) and transition to palliative and end-of-life care.
  - The Canadian Association of Psychosocial Oncology (CAPO) and the Canadian Partnership Against Cancer (the Partnership) guideline Assessment of Psychosocial Health Care Needs of the Adult Cancer Patient suggests screening at initial diagnosis, start of

treatment, regular intervals during treatment, end of treatment, post-treatment or at transition to survivorship, at recurrence or progression, advanced disease, when dying, and during times of personal transition or reappraisal such as family crisis, during post-treatment survivorship and when approaching death.\*

- Screening should be done using a valid and reliable measure that features reportable scores (dimensions) that are clinically meaningful (established cut-offs).\*
- When assessing a person who may have depressive symptoms, a phased screening and assessment is recommended that does not rely simply on a symptom count.
  - As a first step for all patients, identification of the presence or absence of pertinent history or risk factors (see the depression algorithm in the original guideline document) is important for subsequent assessment and treatment decision making.
  - As a second step, two items from the nine-item Patient Health Questionnaire (PHQ-9) (Table 1 in the original guideline document) can be used to assess for the classic depressive symptoms of low mood and anhedonia. For individuals who endorse either item (or both) as occurring for more than half of the time or nearly every day within the last 2 weeks (i.e., a score of  $\geq 2$ ), a third step is suggested in which the patient completes the remaining items of the PHQ-9. It is estimated that 25% to 30% of patients would need to complete the remaining items. The traditional cutoff for the PHQ-9 is  $\geq 10$ . The Panel's recommended cutoff score of  $\geq 8$  is based on a study of the diagnostic accuracy of the PHQ-9 with cancer outpatients. A meta-analysis by Manea et al also supports the  $\geq 8$  cutoff score.
  - For patients who complete the latter step, it is important to determine the associated sociodemographic, psychiatric or health comorbidities, or social impairments, if any, and the duration of depressive symptoms.
  - Of special note, one of remaining seven items of the PHQ-9 assesses thoughts of self-harm (i.e., "Thoughts that you would be better off dead or hurting yourself in some way"). Among patients with moderate to severe or severe depression, such thoughts are not rare. Having noted that, it is the frequency and/or specificity of the thoughts that are most important vis-a-vis risk. Some clinicians may choose to omit the item from the PHQ-9 and administer eight items. It should be noted, however, that doing so may artificially lower the score, with the risk of some patients appearing to have fewer symptoms than they actually do. Such changes also weaken the predictive validity of the score and the clarity of the cutoff scores. It is important to note that individuals do not typically endorse a self-harm item exclusively or independent of other symptoms; rather, it occurs with several other symptom endorsements. Thus, it is the patient's endorsement of multiple symptoms that will define the need for services for moderate to severe symptomatology.
- Consider special circumstances in the assessment of depressive symptoms. These include but are not limited to the following: (1) use culturally sensitive assessments and treatments as is possible, (2) tailor assessment or treatment for those with learning disabilities or cognitive impairments, (3) be aware of the difficulty of detecting depression in the older adult.

## Assessment

- Specific concerns such as risk of harm to self and/or others, severe depression or agitation, or the presence of psychosis or confusion (delirium) require immediate referral to a psychiatrist, psychologist, physician, or equivalently trained professional.
- Assessments should be a shared responsibility of the clinical team, with designation of those who are expected to conduct assessments as per scope of practice.\*
- The assessment should identify signs and symptoms of depression, the severity of cancer symptoms (e.g., fatigue), possible stressors, risk factors, and times of vulnerability. A range of problem checklists is available to guide the assessment of possible stressors. Examples of these are accessible at [www.asco.org/adaptations/depression](http://www.asco.org/adaptations/depression) [redacted]. Clinicians can amend checklists to include areas not represented or ones unique to their patient populations.
- Patients should first be assessed for depressive symptoms using the PHQ-9 (see Table 1 in the original guideline document).
- Table 2 in the original guideline document provides a list of other depressive symptom assessment measures, which can be used in follow-up to the PHQ-9 or as alternatives. Table 2 in the original guideline document was modified to include measures of depression and/or anxiety symptoms only.
- If moderate to severe or severe symptomatology is detected through screening, individuals should have further diagnostic assessment to identify the nature and extent of the depressive symptoms and the presence or absence of a mood disorder.
- Medical or substance-induced causes of significant depressive symptoms (e.g., interferon administration) should be determined and treated.
- As a shared responsibility, the clinical team must decide when referral to a psychiatrist, psychologist, or equivalently trained professional is needed. This includes, for example, all patients with a PHQ-9 score in the severe range or patients in moderate range but with pertinent history and/or risk factors. Such would be determined using measures with established reliability, validity, and utility (e.g., cutoff or normative data available) or standardized diagnostic interviews for assessment and diagnosis of depression.

## Treatment and Care Options

- For any patient who is identified as at risk of harm to self and/or others, refer to appropriate services for emergency evaluation. Facilitate a

safe environment and one-to-one observation, and initiate appropriate harm-reduction interventions.

- First, treat medical causes of depressive symptoms (e.g., unrelieved symptoms such as pain and fatigue) and delirium (e.g., infection or electrolyte imbalance).\*
- For optimal management of depressive symptoms or diagnosed mood disorder, use pharmacologic and/or nonpharmacologic interventions (e.g., psychotherapy, psychoeducational therapy, cognitive-behavioral therapy, and exercise) delivered by appropriately trained individuals.
- These guidelines make no recommendations about any specific antidepressant pharmacologic regimen being better than another. The choice of an antidepressant should be informed by the adverse effect profiles of the medications; tolerability of treatment, including the potential for interaction with other current medications; response to prior treatment; and patient preference. Patients should be warned of any potential harm or adverse effects.\*
- Offer support and provide education and information about depression and its management to all patients and their families, including what specific symptoms and what degree of symptom worsening warrants a call to the physician or nurse.
- Special characteristics of depressive disorders are relevant for diagnosis and treatment, including the following:
  - Many individuals (50% to 60%) with a diagnosed depressive disorder will have a comorbid anxiety disorder, with generalized anxiety being the most prevalent.
  - If an individual has comorbid anxiety symptoms or disorder(s), the usual practice is usually to treat the depression first.
  - Some people have depression that does not respond to an initial course of treatment.
- It is recommended to use a stepped care model and tailor intervention recommendations based on variables such as the following:
  - Current symptomatology level and presence or absence of *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)* diagnosis
  - Level of functional impairment in major life areas
  - Presence or absence of risk factors
  - History of and response to previous treatments for depression
  - Patient preference
  - Persistence of symptoms after receipt of an initial course of depression treatment
- Psychological and psychosocial interventions should derive from relevant treatment manuals for empirically supported treatments that specify the content and guide the structure, delivery mode, and duration of the intervention.
- Use of outcome measures should be routine (minimally pre- and post-treatment) to (1) gauge the efficacy of treatment for the individual patient, (2) monitor treatment adherence, and (3) evaluate practitioner competence.

#### Follow-Up and Reassessment

- It is common for persons with depressive symptoms to lack the motivation necessary to follow through on referrals and/or to comply with treatment recommendations. With this in mind, do the following on a biweekly or monthly basis, until symptoms have remitted:
  - Assess follow-through and compliance with individual or group psychological or psychosocial referrals, as well as satisfaction with these services.
  - Assess compliance with pharmacologic treatment, patient's concerns about adverse effects, and satisfaction with the symptom relief provided by the treatment.
  - If compliance is poor, assess and construct a plan to circumvent obstacles to compliance, or discuss alternative interventions that present fewer obstacles.
  - After 8 weeks of treatment, if symptom reduction and satisfaction with treatment are poor, despite good compliance, alter the treatment course (e.g., add a psychological or pharmacologic intervention, change the specific medication, refer to individual psychotherapy if group therapy has not proved helpful).


#### Recommendations on Screening, Assessment, and Treatment and Care Options for Anxiety Symptoms

Figure 2 in the original guideline document presents a screening and assessment algorithm for anxiety adapted from the pan-Canadian guideline. The algorithm was modified to reflect the ASCO panel's adapted recommendations. Of particular note, references to the ESAS screening measure in the recommendations and the algorithm were removed as this measure is not widely used in the United States.

As noted, where identified by an asterisk, recommendations were taken verbatim from the pan Canadian guideline. Otherwise, recommendations were adapted by the ASCO panel. Recommendations on follow-up and reassessment of symptoms of anxiety are based solely on the consensus of the ASCO panel.

#### Screening

- All health care providers should routinely screen for the presence of emotional distress and specifically symptoms of anxiety from the point of diagnosis onward.\*

- All patients should be screened for distress at their initial visit, at appropriate intervals and as clinically indicated, especially with changes in disease status (i.e., post-treatment, recurrence, progression) and when there is a transition to palliative and end-of-life care.\*
  - The CAPO and Partnership guideline, Assessment of Psychosocial Health Care Needs of the Adult Cancer Patient, suggests screening at initial diagnosis, start of treatment, regular intervals during treatment, end of treatment, post-treatment or at transition to survivorship, at recurrence or progression, advanced disease, when dying, and during times of personal transition or reappraisal such as family crisis, during post-treatment survivorship and when approaching death.\*
- Screening should identify the level and nature (problems and concerns) of the distress as a red flag indicator.\*
- Screening should be done using a valid and reliable tool that features reportable scores (dimensions) that are clinically meaningful (established cut-offs).\*
- Anxiety disorders include specific phobias and social phobia, panic and agoraphobia, generalized anxiety disorder (GAD), obsessive compulsive disorder, and post-traumatic stress disorder (PTSD).
- It is recommended that patients be assessed for GAD, as it is the most prevalent of all anxiety disorders and it is commonly comorbid with others, primarily mood disorders or other anxiety disorders (e.g., social anxiety disorder).
- Use of the Generalized Anxiety Disorder (GAD)-7 scale (see Table 1 in the original guideline document) is recommended. Table 2 in the original guideline document provides a list of other assessment measures for symptoms of anxiety, nervousness, and GAD. Table 2 in the original guideline document was modified to include scales that measure depression and/or anxiety only.
- Patients with GAD do not necessarily present with symptoms of anxiety, per se. The pathognomic GAD symptom (i.e., multiple excessive worries) may present as "concerns" or "fears." Whereas cancer worries may be common for many, GAD worry or fear may be disproportionate to actual cancer-related risk (e.g., excessive fear of recurrence, worry about multiple symptoms or symptoms not associated with current disease or treatments). Importantly, an individual with GAD has worries about a range of other, non-cancer topics and areas of his or her life.
- It is important to determine the associated home, relationship, social, or occupational impairments, if any, and the duration of anxiety-related symptoms. As noted above, problem checklists can be used. Examples of these are accessible at [www.asco.org/adaptations/depression](http://www.asco.org/adaptations/depression) . Clinicians can amend the checklists to include additional key problem areas or ones unique to their patient populations.
- As with depressive symptoms, consider special circumstances in screening and assessment of anxiety, including using culturally sensitive assessments and treatments and tailoring assessment or treatment for those with learning disabilities or cognitive impairments.

## Assessment

- Specific concerns such as risk of harm to self and/or others, severe anxiety or agitation, or the presence of psychosis or confusion (delirium) require referral to a psychiatrist, psychologist, physician, or equivalently trained professional.
- When moderate to severe or severe symptomatology is detected through screening, individuals should have a diagnostic assessment to identify the nature and extent of the anxiety symptoms and the presence or absence of an anxiety disorder or disorders.
- Medical and substance-induced causes of anxiety should be diagnosed and treated.
- As a shared responsibility, the clinical team must decide when referral to a psychiatrist, psychologist or equivalently trained professional is needed (i.e., all patients with a score in the moderate to severe or severe range, with certain accompanying factors and/or symptoms, identified using valid and reliable measures for assessment of symptoms of anxiety).
- Assessments should be a shared responsibility of the clinical team, with designation of those who are expected to conduct assessments as per scope of practice.\*
- The assessment should identify signs and symptoms of anxiety (e.g., panic attacks, trembling, sweating, tachypnea, tachycardia, palpitations, and sweaty palms), severity of symptoms, possible stressors (e.g., impaired daily living), risk factors, and times of vulnerability, and should also explore underlying problems/causes.\*
- A patient considered to have severe symptoms of anxiety after the further assessment should, where possible, have confirmation of an anxiety disorder diagnosis before any treatment options are initiated (e.g., *DSM-IV*, which may require making a referral).

## Treatment and Care Options

- For any patient who is identified as at risk of harm to self and/or others, clinicians should refer to appropriately trained professionals for emergency evaluation. Facilitate a safe environment and one-to-one observation, and initiate appropriate harm-reduction interventions.
- It is suggested that the clinical team making a patient referral for the treatment of anxiety review with the patient, in a shared decision process, the reason(s) for and potential benefits of the referral. Further, it is suggested that the clinical team subsequently assess the patient's compliance with the referral and treatment progress or outcomes.
- First treat medical causes of anxiety (e.g., unrelieved symptoms such as pain and fatigue) and delirium (e.g., infection or electrolyte imbalance).\*

- For optimal management of moderate to severe or severe anxiety, consider pharmacologic and/or nonpharmacologic interventions delivered by appropriately trained individuals. Management must be tailored to individual patients, who should be fully informed of their options.
- For a patient with mild to moderate anxiety, the primary oncology team may choose to manage the concerns by usual supportive care.\*
- The choice of an anxiolytic should be informed by the adverse effect profiles of the medications; tolerability of treatment, including the potential for interaction with other current medications; response to prior treatment; and patient preference. Patients should be warned of any potential harm or adverse effects. Caution is warranted with respect to the use of benzodiazepines in the treatment of anxiety, specifically over the longer term. These medications carry an increased risk of abuse and dependence and are associated with adverse effects that include cognitive impairment. As a consequence, use of these medications should be time limited in accordance with established psychiatric guidelines.
- Offer support and provide education and information to all patients and their families about anxiety and its treatment and what specific symptoms or symptom worsening warrant a call to the physician or nurse.
- It is recommended to use a stepped care model to tailor intervention recommendations on the basis of variables such as the following:
  - Current symptomatology level and presence/absence of *DSM-V* diagnoses
  - Level of functional impairment in major life areas
  - Presence/absence of risk factors
  - Chronicity of GAD and response to previous treatments, if any
  - Patient preference
  - Persistence of symptoms after receipt of the current anxiety treatment.
- Psychological and psychosocial interventions should be derived from relevant treatment manuals of empirically supported treatments that specify the content and guide the structure, delivery mode, and duration of the intervention. Use of outcome measures should be routine (minimally pre and post-treatment) to (1) gauge the efficacy of treatment for the individual patient, (2) monitor treatment adherence, and (3) evaluate practitioner competence.

#### Follow-Up and Reassessment

- Because cautiousness and a tendency to avoid threatening stimuli are cardinal features of anxiety pathology, it is common for persons with symptoms of anxiety not to follow through on potentially helpful referrals or treatment recommendations. With this in mind, it is recommended that the mental health professional or other member of the clinical team treating the patient's anxiety, on a monthly basis or until symptoms have subsided:
  - Assess follow-through and compliance with individual or group psychological or psychosocial referrals, as well as satisfaction with the treatment.
  - Assess compliance with pharmacologic treatment, patient's concerns about adverse effects, and satisfaction with the symptom relief provided by the treatment.
  - Consider tapering the patient from medications prescribed for anxiety if symptoms are under control and if the primary environmental sources of anxiety are no longer present. Longer periods of tapering are often necessary with benzodiazepines, particularly with potent or rapidly eliminated medications.
  - If compliance is poor, assess and construct a plan to circumvent obstacles to compliance, or discuss alternative interventions that present fewer obstacles.
  - After 8 weeks of treatment, if symptom reduction and satisfaction with treatment are poor, despite good compliance, alter the treatment course (e.g., add a psychological or pharmacologic intervention, change the specific medication, refer to individual psychotherapy if group therapy has not proved helpful).

## Clinical Algorithm(s)

The following algorithms are provided in the original guideline document:

- Screening and Assessment – Depression in Adults with Cancer
- Care Map – Depression in Adults with Cancer
- Screening and Assessment – Anxiety in Adults with Cancer
- Care Map – Generalized Anxiety in Adults with Cancer

## Scope

## Disease/Condition(s)

Cancer

## Other Disease/Condition(s) Addressed

- Anxiety
- Depression

## Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

## Clinical Specialty

Family Practice

Nursing

Oncology

Psychiatry

Psychology

## Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

## Guideline Objective(s)

To present the optimum screening, assessment, and treatment approaches in the treatment of adult patients with cancer who are experiencing

## Target Population

Adults (age 18 years and older) at any phase of the cancer continuum and regardless of cancer type, disease stage, or treatment modality

Note: The guideline does not focus on treatment of depression or anxiety in adults prior to a cancer diagnosis, but recognizes these as risk factors in the assessment process.

## Interventions and Practices Considered

### Depression Screening/Assessment

1. Screening for depressive symptoms using a valid, reliable measure with reportable scores
2. Pertinent history/risk assessment
3. Patient Health Questionnaire (PHQ-9)
4. Determination of the associated sociodemographic, psychiatric or health comorbidities, or social impairments and duration of depressive symptoms
5. Determination of medical or substance-induced causes of significant depressive symptoms
6. Consideration of special circumstances (culturally sensitive assessments)
7. Immediate referral to a psychiatrist in cases where there is risk of harm to self and/or others, severe depression or agitation, or the presence of psychosis or confusion (delirium)
8. Shared clinical team responsibility for referral to a psychiatrist, psychologist, or equivalently trained professional

### Depression Management/Treatment

1. Emergency evaluation for patients at risk of harm to self and/or others
2. Treatment of medical causes of depressive symptoms (e.g., unrelieved symptoms such as pain and fatigue) and delirium (e.g., infection or electrolyte imbalance)
3. Nonpharmacologic management (e.g., psychotherapy, psychoeducational therapy, cognitive-behavioral therapy, and exercise)
4. Pharmacologic management (antidepressants)
5. Patient/family education
6. Consideration of special characteristics of depressive disorders (comorbid anxiety disorder)
7. Stepped care model
8. Use of routine outcome measures
9. Follow-up and reassessment after 8 weeks of treatment

### Anxiety Screening/Assessment

1. Routine screening for the presence of emotional distress and symptoms of anxiety using valid and reliable tool with reportable scores
2. Assessment for Generalized Anxiety Disorder (GAD) using GAD-7 scale
3. Determination of associated home, relationship, social, or occupational impairments, and the duration of anxiety-related symptoms
4. Consideration of special circumstances (culturally sensitive assessments)
5. Referral to a psychiatrist, psychologist, physician, or equivalently trained professional if risk of harm to self and/or others, severe anxiety or agitation, or presence of psychosis or confusion (delirium)
6. Diagnostic assessment to identify the nature and extent of the anxiety symptoms and presence of an anxiety disorder
7. Determination and management of medical or substance-induced causes of anxiety
8. Shared responsibility by the clinical team for assessment and referral
9. Identification of signs and symptoms of anxiety (e.g., panic attacks, trembling, sweating, tachypnea, tachycardia, palpitations, and sweaty palms), severity of symptoms, possible stressors (e.g., impaired daily living), risk factors, and times of vulnerability, and underlying problems/causes

### Anxiety Management/Treatment

1. Emergency evaluation and management for patients identified as at risk of harm to self and/or others
2. Shared clinical team and patient decision making
3. Management of medical causes of anxiety (e.g., unrelieved symptoms such as pain and fatigue) and delirium (e.g., infection or electrolyte



imbalance)

4. Pharmacologic (anxiolytics) management
5. Nonpharmacologic management of moderate to severe anxiety
6. Patient/family education
7. Stepped care model
8. Follow-up and assessment after 8 weeks of treatment

## Major Outcomes Considered

- Quality of life
- Symptom control
- Treatment adherence
- Treatment efficacy

## Methodology

### Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

### Description of Methods Used to Collect/Select the Evidence

The adaptation process starts with a literature search to identify candidate guidelines for adaptation on a given topic. The systematic search of clinical practice guideline databases, guideline developer Web sites, and the published health literature identified clinical practice guidelines, systematic reviews, meta-analyses, and other guidance documents addressing the screening, assessment, and care of symptoms of anxiety and/or depression.

The literature search included MEDLINE and EMBASE databases, and the Cochrane Library. To identify guidelines not indexed in medical databases, an environmental scan was undertaken of guideline databases such as the Standards and Guidelines Evidence (SAGE) Directory of Cancer Guidelines. Finally, websites of organizations developing guidelines and medical specialty websites were searched and a Google™ search was undertaken to ensure that no guidelines were missed.

The guideline searches used combinations of the following search terms: depression, anxiety, cancer, guideline, review. Guidelines and reviews were excluded if they were published before 2009 and if they were written in a language other than English. Guidelines and reviews based on a clearly described systematic literature search were preferred; however, expert consensus guidance was also included for consideration. Narrative reviews and abstracts were excluded.

A Pan-Canadian Practice Guideline on Screening, Assessment, and Care of Psychosocial Distress (Depression, Anxiety) in Adults With Cancer was identified for adaptation on the basis of formal content review using a standardized form and on review of the literature search yield. The ad hoc panel selected the pan-Canadian guideline for adaptation because it was comprehensive and recently developed by multidisciplinary panels of experts. See the methodology supplement (see the "Availability of Companion Documents" field) for details of the search and content review.

Refer to the original guideline document for development methodology and key evidence for the pan-Canadian guideline.

### Number of Source Documents

Not stated



## Methods Used to Assess the Quality and Strength of the Evidence

Not stated

## Rating Scheme for the Strength of the Evidence

Not applicable

## Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

## Description of the Methods Used to Analyze the Evidence

The methodologic review of the pan-Canadian guideline was completed independently by two American Society of Clinical Oncology (ASCO) guideline staff members using the Rigour of Development subscale from the Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument. The score for the Rigour of Development domain is calculated by summing the scores across individual items in the domain and standardizing the total score as a proportion of the maximum possible score. Detailed results of the scoring for this guideline are available on request to [guidelines@asco.org](mailto:guidelines@asco.org). Overall, the pan-Canadian guideline score was 83.3% for methodological quality, with only minor deviations from the ideal as reflected in the AGREE II items.

The guideline underwent a content review by the Depression and Anxiety expert panel. The panel members were asked to complete an 8-item Guideline Endorsement Content Review Form (see Appendix 2 in the methodology supplement [see the "Availability of Companion Documents" field]) that assessed the perceived clarity and clinical utility of the recommendations, and the degree to which the recommendations are consistent with the content reviewers' interpretation of the available data on the topic in question. This form was adapted by ASCO from the Cancer Care Ontario Program in Evidence-Based Care Practitioner Feedback instrument.

The content review is completed by an ad hoc Panel convened by ASCO that includes multidisciplinary representation in medical oncology, palliative oncology, psychiatry, general internal medicine, nursing, guideline methodology, implementation research and patient representation. The Panel is led by two Co-Chairs who have the primary responsibility for the development and timely completion of the guideline adaptation. Recommendations from the source guidelines are extracted into a summary matrix in cases where more than one guideline is considered.

## Methods Used to Formulate the Recommendations

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

This guideline adaptation was informed by the ADAPTE methodology, which was used as an alternative to de novo guideline development for this guideline. Adaptation of guidelines is considered by the American Society of Clinical Oncology (ASCO) in selected circumstances, when one or more quality guidelines from other organizations already exist on the same topic. The objective of the ADAPTE process is to take advantage of existing guidelines in order to enhance efficient production, reduce duplication, and promote the local uptake of quality guideline recommendations.

ASCO's adaptation process begins with a literature search to identify candidate guidelines for adaptation. Adapted guideline manuscripts are reviewed and approved by the ASCO Clinical Practice Guidelines Committee (CPGC). The review includes two parts: methodological review and content review. The methodological review is completed by a member of the CPGC's Methodology Subcommittee and/or by ASCO senior guideline staff. The content review is completed by an ad hoc panel (see Appendix 1 in the original guideline document) convened by ASCO that includes multidisciplinary representation. Further details of the methods used for the development of this guideline are reported in the methodology supplement (see the "Availability of Companion Documents" field).

On the basis of formal content review of the pan-Canadian guideline, the ASCO panel agreed that, in general, the recommendations were clear,

thorough, based on the most relevant scientific evidence, and presented options that will be acceptable to patients. However, for some topics, the ASCO panel formulated a set of adapted recommendations based on local context and practice beliefs of the ad hoc panel members. Additional guidelines and systematic reviews identified in the literature search were used as a supplementary evidence base to inform these adapted recommendations.

## Rating Scheme for the Strength of the Recommendations

Not applicable

## Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

## Method of Guideline Validation

Internal Peer Review

## Description of Method of Guideline Validation

Final review and approval is completed by the American Society of Clinical Oncology (ASCO) Clinical Practice Guidelines Committee (CPGC) after approval by the ASCO Panel.

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

Appropriate screening, assessment, and management of anxiety and depression in adults with cancer

### Potential Harms

Adverse effects of pharmacological treatment

## Qualifying Statements

### Qualifying Statements

The information contained in, including but not limited to clinical practice guidelines and other guidance is based on the best available evidence at the time of creation and is provided by the American Society of Clinical Oncology, Inc. ("ASCO") to assist providers in clinical decision making. The information should not be relied on as being complete or accurate, nor should it be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. With the rapid development of scientific knowledge, new evidence may emerge between the time

information is developed and when it is published or read. The information is not continually updated and may not reflect the most recent evidence. The information addresses only the topics specifically identified therein and is not applicable to other interventions, diseases, or stages of diseases. This information does not mandate any particular product or course of medical treatment. Further, the information is not intended to substitute for the independent professional judgment of the treating provider, as the information does not account for individual variation among patients. Recommendations reflect high, moderate or low confidence that the recommendation reflects the net effect of a given course of action. The use of words like "must," "must not," "should," and "should not" indicate that a course of action is recommended or not recommended for either most or many patients, but there is latitude for the treating physician to select other courses of action in certain cases. In all cases, the selected course of action should be considered by the treating provider in the context of treating the individual patient. Use of the information is voluntary. ASCO provides this information on an "as is" basis, and makes no warranty, express or implied, regarding the information. ASCO specifically disclaims any warranties of merchantability or fitness for a particular use or purpose. ASCO assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this information or for any errors or omissions.

## Implementation of the Guideline

### Description of Implementation Strategy

For information on the American Society for Clinical Oncology (ASCO) implementation strategy, please see the [ASCO Web site](#)

### Implementation Tools

Clinical Algorithm

Patient Resources

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

## Institute of Medicine (IOM) National Healthcare Quality Report Categories

### IOM Care Need

Getting Better

Living with Illness

### IOM Domain

Effectiveness

Patient-centeredness

## Identifying Information and Availability

## Bibliographic Source(s)

Andersen BL, DeRubeis RJ, Berman BS, Gruman J, Champion VL, Massie MJ, Holland JC, Partridge AH, Bak K, Somerfield MR, Rowland JH, American Society of Clinical Oncology. Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American Society of Clinical Oncology guideline adaptation. *J Clin Oncol*. 2014 May 20;32(15):1605-19. [87 references] [PubMed](#)

## Adaptation

The guideline was adapted from the Pan-Canadian Guideline on Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer.

## Date Released

2014 May 20

## Guideline Developer(s)

American Society of Clinical Oncology - Medical Specialty Society

## Source(s) of Funding

American Society of Clinical Oncology

## Guideline Committee

Depression and Anxiety Expert Panel

## Composition of Group That Authored the Guideline

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## Financial Disclosures/Conflicts of Interest

The Expert Panel was assembled in accordance with the American Society of Clinical Oncology (ASCO) Conflict of Interest Management Procedures for Clinical Practice Guidelines ("Procedures," summarized at <http://www.asco.org/rwi> [redacted]). Members of the panel completed ASCO's disclosure form, which requires disclosure of financial and other interests that are relevant to the subject matter of the guideline, including relationships with commercial entities that are reasonably likely to experience direct regulatory or commercial impact as the result of promulgation of the guideline. Categories for disclosure include employment relationships, consulting arrangements, stock ownership, honoraria, research funding, and expert testimony. In accordance with the Procedures, the majority of the members of the panel did not disclose any such relationships.

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The author(s) indicated no potential conflicts of interest.

## Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Guideline Availability

Electronic copies: Available from the [Journal of Clinical Oncology Web site](#) .

Print copies: Available from American Society of Clinical Oncology, Cancer Policy and Clinical Affairs, 2318 Mill Rd, Suite 800, Alexandria, VA 22314; E-mail: [guidelines@asco.org](mailto:guidelines@asco.org)

## Availability of Companion Documents

The following are available:

- Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American Society of Clinical Oncology guideline adaptation. Methodology supplement. Alexandria (VA): American Society of Clinical Oncology; 2014. 6 p. Electronic copies: Available from the [American Society of Clinical Oncology \(ASCO\) Web site](#) .
- Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American Society of Clinical Oncology guideline adaptation. Slide set. Alexandria (VA): American Society of Clinical Oncology; 2014. Electronic copies: Available in [PDF](#)  and [PowerPoint](#)  from the ASCO Web site.
- Screening, assessment, and care of anxiety and depressive symptoms in adults with cancer: an American Society of Clinical Oncology guideline adaptation. Summary of recommendations. Alexandria (VA): American Society of Clinical Oncology; 2014. 10 p. Electronic copies: Available from the [ASCO Web site](#) .

## Patient Resources

The following is available:

- Depression. Patient information. 2014 Apr 20. Electronic copies: Available from the [Cancer.Net Web site](#) . Also available as a podcast from the [Cancer.Net Web site](#) .
- Anxiety. Patient information. 2014 Apr 20. Electronic copies: Available from the [Cancer.Net Web site](#) . Also available as a podcast from the [Cancer.Net Web site](#) .

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